Letters

CMAJ publishes as many letters from our readers as possible. However, since space is limited, choices have to be made, on the basis of content and style. Letters that are clear, concise and convenient to edit (no longer than two double-spaced typescript pages, or 450 words) are more likely to be accepted. Those that are single-spaced, handwritten or longer than 450 words will usually be returned or not published. We reserve the right to edit letters for clarity and to abridge those that are unduly long or repeat points made in other letters, especially in the same issue.

Residency training in internal medicine: program design in an era of constraint

Dr. Tim W. Meagher claims in his article (*Can Med Assoc J* 1988; 138: 705–708) that the program for training residents in internal medicine at the Montreal General Hospital ensures "exposure to all the key elements of internal medicine in 3 years" and that the subspecialties "represent the most important fields for a general internist" and are "appropriate for an internal medicine practice in North America". He states that the amount of time spent in each subspecialty is decided by several criteria, such as "the prevalence of problems in that subspecialty in a general internal medicine practice in North America" and "the likelihood that knowledge in that area will not be gained from a rotation in general medicine".

I was therefore surprised to see that the subspecialty of geriatric medicine, which surely fulfils each of these criteria, is not included in the core rotations and utterly amazed that it is not offered even as an elective rotation. That ophthalmology and gynecology are considered more important than geriatric medicine suggests to me that either the case mix of patients within the clinical teaching units of the Montreal General Hospital is very different from that in the rest of Canada or the high prevalence of problems among that hospital's elderly patients and the benefits offered by a geriatric service have been overlooked.

Geriatric medicine is recognized by the Royal College of Physicians and Surgeons of Canada as a legitimate subspecialty within internal medicine. Authoritative bodies such as the CMA[1] have recommended that a rotation in geriatric medicine be considered mandatory in internal medicine training, a situation that already exists within several Canadian medical schools.

The multidisciplinary geriatric approach is of proven benefit in inpatient assessment units,[2] day hospitals[3] and consultation services,[4] and to ignore the importance of this subspecialty in the face of the striking demographic changes across Canada is to bury one's head in the anachronistic sands of traditional medical conservatism.

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References

1. Canadian Medical Association: *Health Care for the Elderly: Today's Challenges, Tomorrow's Options. Report of the CMA Committee on the Health Care of the Elderly*, Can Med Assoc, Ottawa, 1987
2. Rubenstein LZ, Josephson KR, Wieland GD et al: Effectiveness of a geriatric evaluation unit. A randomized clinical trial. *N Engl J Med* 1984; 311: 1664–1670
3. Eagle DJ, Guyatt G, Patterson C et al: Day hospitals' cost and effectiveness: a summary. *Gerontologist* 1987; 27: 735–740
4. Hogan DB, Fox RA, Badley BWD et al: Effect of a geriatric consultation service on management of patients in an acute care hospital. *Can Med Assoc J* 1987; 136: 713–717

As a member of an emerging subspecialty of internal medicine that is still in its infancy and is struggling to compete with more established subspecialties I was curious to see how my discipline would be incorporated into the program Dr. Meagher describes. I was shocked to find no mention of geriatric medicine whatsoever.

Although frail elders are already heavy users of general medical services, although their numbers will triple before the turn of the century, and despite the growing body of scientific evidence for the efficacy and cost-effectiveness of geriatric services,[1-3] geriatric medicine rates somewhere below tropical medicine in perceived relevance at the Montreal General Hospital. This seems absurd considering the criteria that Meagher outlines for determining the amount of time spent in each subspecialty. Perhaps it was considered that general medical services teach geriatric skills adequately. I submit that if this is the rationale, there is little evidence to substantiate it. In fact, cognitive impairment and gait disorders that geri-

atricians in these institutions are typically deluged with is evidence to the contrary.

While this letter may leave me open to a charge of drumbeating for the vested interests of my subspecialty, the real purpose is to draw attention to a phenomenon in internal medicine that I believe Meagher's article illustrates: the persistent and almost perseverative blindness of internal medicine departments to the significant shortcomings of care for the elderly in hospitals. Nurses, rehabilitation workers and discharge planners are regularly outraged at the repeated occurrence of inappropriate, insensitive care for the elderly even in first-rate teaching hospitals, yet prestigious departments of internal medicine seem to consider these problems less important in Canada than malaria and schistosomiasis. I yearn for the day when they will show a firmer grasp of contemporary reality.

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References

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2. Rubenstein LZ, Josephson KR, Wieland GD et al: Effectiveness of a geriatric evaluation unit. A randomized clinical trial. *N Engl J Med* 1984; 311: 1664-1670

3. Williams ME, Williams TF, Zimmer JG et al: How does the team approach to outpatient geriatric evaluation compare with traditional care: a report of a randomized controlled trial. *J Am Geriatr Soc* 1987; 35: 1071-1078

I was appalled to read Dr. Meagher's article. To construct a residency training program in internal medicine without considering appropriate exposure to geriatrics is an incredibly backward step. I think doctors are still falling into the trap of training physicians to meet the needs of other physicians rather than the needs of society.

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The increase in numbers of the elderly in Canada has been acknowledged by the CMA as having major implications for medical education.[1] Geriatric medicine is a recognized subspecialty of internal medicine (unlike tropical medicine, which Dr. Meagher does mention), but we observe that the general medical ward is a poor environment in which to learn the principles of care for and consultation on elderly patients. It seems obvious, therefore, that geriatrics should be a core rotation in any modern teaching program.

At the University of Manitoba first-year and second-year residents rotate through an acute geriatric medicine service for 2 months, and this is counted as part of their ward medicine experience. Certainly the types of problems encountered include those found on any general medical service. The residents receive teaching in the inpatient care of the elderly (including active consultation) as well as exposure to outpatient management, through geriatric day hospitals, home visits (a new experience for most of our trainees) and a rural consultation service.

We believe that the experience obtained on such a geriatric service is both unique and integral to any well-rounded training program that hopes to produce practitioners suited for medicine in the 21st century. Counting geriatrics as a general ward medicine rotation is appropriate and preserves time for other more technical and narrowly focused subspecialties. We hope that other programs across Canada will consider this model.

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Reference

1. Canadian Medical Association: *Health Care for the Elderly: Today's Challenges, Tomorrow's Options. Report of the CMA Committee on the Health Care of the Elderly*, Can Med Assoc, Ottawa, 1987

Dr. Meagher refers to "the American College of Graduate Medical Education (ACGME)" and quotes some observations from the reference cited. I have never heard of such a college but do know that the acronym ACGME stands for Accreditation Council for Graduate Medical Education. The observations are from the 1986-87 edition of the *Directory of Residency Training Programs* (American Medical Association, Chicago) and not from the 1985-86 edition, as indicated in the reference. The internal medicine "essentials" outlined on pages 35 and 36 of the 1986-87 edition became effective in July 1986. There is in the 1985-86 edition a set of observations that is similar, though somewhat differently worded; it appears on pages 32 and 33, not pages 35 and 36, and became effective in July 1980, not on July 1, 1982, as indicated in the reference.

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[Dr. Meagher responds:]

Our clinical teaching units, presumably like those in the rest of Canada, are made up predominantly of elderly patients. During rotations through these units the house staff have ample time to become fully familiar with illnesses presenting in the elderly. There is also an active geriatric consultation service, which interacts with the clinical teaching unit and emphasizes the specific problems of the elderly.

As a result, I believe that medical residents become quite competent in handling geriatric patients with the present clinical teaching unit exposure. I agree, however, that certain specific